Request and authorisation for release of dental records

ST. QUENTIN DENTAL

Patient details

Patient name: D.O.B: / /

Residential address:

Suburb: Postcode: State:

I hereby express written consent and request that all my dental and medical records be released from

to St Quentin Dental in time for an upcoming appointment with the practice.

Appointment date:

Please forward copies of these records via email to reception2@stquentindental.com.au or by registered mail, courier or personal delivery.

To: Dr of:

St Quentin Dental
247 Stirling Highway
Cnr Reserve Street
Claremont WA 6010

Digital photographs or radiographs can be emailed to reception2@stquentindental.com.au.

Copies of the following are specifically requested:

- ☐ Medical history forms
- ☐ Progress notes
- ☐ Letters and reports to/from specialists
- ☐ Periodontal charting
- ☐ Radiographs

If there are any queries, please contact St Quentin Dental, Claremont on (08) 9385 2418.

Kindest regards,

Signature

Patient name: Signature: Date:

Parent/guardian signature (if applicable):